SDRMA GOLD PPO 80/50 Custom PPO

Benefit Summary (For groups of 300 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE, DISCLOSURE FORM* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Effective August 1, 2006

DEDUCTIBLES# (All Providers combined)	**Preferred Providers**[1]	**Non-Preferred Providers**[1]
Calendar-year Medical Deductible		
• Per individual/per family	$500 / $1,000	
Calendar-year Copayment Maximum#		
• Per individual/per family	$1,500 / $3,000	
LIFETIME MAXIMUMS	$5,000,000	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES		
Physician services		
• Physician and specialist office visits	$20 / Visit*#	50%#
• Laboratory and X-rays	20%	50%
• Allergy testing or treatment	20%	50%
• Diagnostic testing	20%	50%
Preventive care		
• Annual routine physical exam, eye/ear screenings and immunizations (Maximum allowed per member (Employee and Spouse only) per calendar year is $200 for routine physical exams including well woman exam)	20%*	50%*
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)	20%*	50%*
Well-baby care		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	$20 / Visit*#	50%*
• Laboratory	20%*	50%*
OUTPATIENT SERVICES		
• Outpatient surgery in performed in Ambulatory Surgery Center (ASC)[2]	20%	$50 / surgery# + 50%[3]
• Outpatient surgery in hospital/facility	20%	$50 / surgery# + 50%[3]
• Outpatient treatment and necessary supplies	20%	50%[3]
HOSPITALIZATION SERVICES		
• Inpatient physician services (including pregnancy and maternity care)	20%	50%
• Semi-private room and board, medically necessary services and supplies (includes acute medical detoxification)	20%	50%[3]
Skilled nursing facility (SNF) services (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Freestanding SNF	20%	20% with prior authorization[4]
• Hospital SNF unit	20%	50%[3]
EMERGENCY HEALTH COVERAGE		
• Facility services (Not resulting in a direct admission)	$50# + 20%	
• Facility services (Resulting in a direct admission)	20%	20%
• Emergency room physician services	20%	20%
AMBULANCE SERVICES	20%	20%
DURABLE MEDICAL EQUIPMENT		
Home medical equipment, prosthetics/orthotics	20%	50%
MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES		
• Inpatient facility services for Acute Medical Detoxification	20%	50%[3]
• Inpatient facility services for mental illness and substance abuse (Up to 30 days per calendar year)	No Charge*#	Not Covered
• Outpatient mental illness (Up to 50 visits per calendar year)	Visits 1–6: No Charge*# Visits 7–20: $15/visit*# Visits 21–50: $30/visit*#	$100 deductible per calendar year; 50%, maximum allowed $40 per visit*#
• Outpatient substance abuse (One chemical dependency treatment program per calendar year; three per lifetime)	No Charge*#	$100 deductible per calendar year; 50%, maximum allowed $1000 per program*#

Covered Services	Member Copayment	
HOME HEALTH SERVICES[4]		
(Combined maximum of 100 prior authorized visits per calendar year)		
• Home health and home infusion care (See "Prescription Drug Coverage" for home self-administered injectables.)	20%	20% with prior authorization
OTHER		
Hospice[4]		
(Combined maximum of $10,000 per member per lifetime)		
• Routine home care and inpatient respite care	20%	20% with prior authorization
• 24 hour continuous home care and general inpatient care	20%	20% with prior authorization
Alternative care[5]	**Preferred Providers**[1]	**Non-Preferred Providers**[1]
• Chiropractic services (Up to 26 visits per calendar year)	20% (Max allowed $50 / visit)	50% (Max allowed $25 / visit)
• Acupuncture services	20%	50%
Rehabilitative therapy services		
• Outpatient visits	20%	50%
Pregnancy and maternity care		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	20%	50%
Family planning		
• Family planning counseling	$20 / Visit*#	Not Covered
• Elective abortion, tubal ligation, vasectomy[6]	20%	Not Covered
Covered out-of-state benefits Benefits provided through BlueCard® Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.	20% or $20 copay	50%
Diabetes care		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.")	20%	50%
• Self-management training and education (If billed by our provider, you will also be responsible for the office visit copayment)	$20 / Visit*#	50%#
Optional Benefits	Optional dental, vision, inpatient substance abuse treatment, or infertility benefit is available. If your employer purchased any of these benefits, a description of the benefit is provided separately.	

* Benefits are not subject to the calendar-year medical deductible.

\# **Deductible and copayments marked with a (#) do not accrue to calendar-year copayment maximum**. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the *Evidence of Coverage*, the *Disclosure Form* and the *Group Health Service Contract* for exact terms and conditions of coverage.

1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

2 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.

3 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for the copayment percent of this $600 per day, plus all charges in excess of $600.

4 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.

5 All outpatient acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

6 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

Benefits are subject to modification for subsequently enacted state or federal legislation.